ATTACHMENT 1
Procedure code conversion chart for physician services

The following table lists the national procedure codes providers will be required to use in lieu of Wisconsin Medicaid local codes when submitting claims for physician services. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Providers should refer to their service-specific *Updates* and handbooks for other nationally recognized procedure codes Wisconsin Medicaid covers for physician services.

Before HIPAA implementation	**After HIPAA implementation**	
Local procedure code and description	**Replaced by procedure code and description**	**Modifier and description**
W6000 Antepartum care; initial visit	**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components: • a comprehensive history; • a comprehensive examination; • medical decision making of moderate complexity. Usually, the presenting problems are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.	**TH*** (obstetrical treatment/ services, prenatal)
W6001 Antepartum care; two or three visits	**99213** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: • an expanded problem focused history; • an expanded problem focused examination; • medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.	**TH*** (obstetrical treatment/ services, prenatal)
W6020 Infant Head Molding Bands	**L0100**** Cranial orthosis (helmet), with or without soft interface, molded to patient model	

*Providers are required to use modifier "TH" with procedure codes 99204 and 99213 only when those codes are used to indicate the first three antepartum care visits. Providers are required to use both modifiers "TH" and the appropriate Health Professional Shortage Area (HPSA) modifier when these prenatal services are HPSA eligible.

**Medicaid reimbursement for L0100 covers all services necessary to fit and adjust the head molds, including the cost of the molds and headbands.

Providers should use this as a guide for submitting claims for a specific number of antepartum care visits.

Antepartum care claims submission guide for use after HIPAA implementation			
Total visit(s)	**Procedure code and modifier (if applicable)**	**Description**	**Quantity**
One	**99204 + TH**	See previous chart.	1.0
Two	**99204 + TH**	See previous chart.	1.0
	99213 + TH	See previous chart.	1.0
Three	**99204 + TH**	See previous chart.	1.0
	99213 + TH	See previous chart.	2.0
Four to six	**59425**	Antepartum care only; 4-6 visits	1.0
Seven +	**59426**	7 or more visits	1.0